State of California—Health and Human Services Agency
Department of Health Care Services

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RE: California Bridge to Reform Demonstration (No. 11-W-00193/9) Amendment Tribal Health Programs Uncompensated Care / California Rural Indian Health Board (CRIHB) Facility Payment Demonstration

Dear Ms. Hossain, Ms. Garner, Ms. Terwilliger, and Ms. Lee:

The State of California proposes to amend the Special Terms and Conditions (STC) and Expenditure Authority of Waiver 11-W-00193/9, California Section 1115 "Bridge to Reform" Demonstration, pursuant to STC paragraph 7. The proposed amendment

would permit the Department of Health Care Services (DHCS) to make uncompensated care payments for optional services eliminated from the state plan provided by Indian Health Service (IHS) tribal health programs operating under the authority of Indian Self-Determination and Education Assistance Act (ISDEAA) to IHS-eligible Medi-Cal beneficiaries. This proposal seeks to extend the section 1115 amendment approved by the Centers for Medicare and Medicaid Services (CMS) in California in April 2013, through the duration of the existing 1115 Waiver.

The State is requesting that this waiver amendment have an effective date of January 1, 2015, and an end date of October 31, 2015. The State is prepared to work diligently to respond to any questions or provide any information CMS may need in order to secure prompt approval of this amendment, allowing for a seamless continuation of program authority through the duration of current Waiver authority.

Background

The CRIHB is a tribal organization contracting under Indian Self-Determination and Education Assistance Act (ISDEAA) that provides medical assistance as a facility of the IHS through a subcontracting process with seven tribal health programs. Additionally the CRIHB serves as the central administrator for the Tribal Medicaid Administrative Activities (MAA) program through contracts with 17 Tribal Health Programs operating in California.

CRIHB subcontracts with most of the state's 33 tribal health programs in the Contract Health Service Delivery Area (CHSDA). These tribal health programs would be eligible to participate in the proposed facility payment demonstration project's provider network. The proposed demonstration would provide uncompensated care payments using the IHS encounter rate for Medi-Cal state plan primary care services and other optional services eliminated from the state plan.

For individuals enrolled in the Medi-Cal program, the proposed demonstration would only provide uncompensated care payments using the IHS encounter rate for optional services eliminated from the state plan.

IHS eligible individuals receiving care at these facilities would continue to receive acute care hospital and specialty care services as they do now through the IHS health service referral system. Services will continue to be provided in these tribal facilities to non-IHS beneficiaries according to the eligibility policy currently in place as established and authorized by Indian Health Care Improvement Act (IHCIA) by the individual tribal health program and as approved by the IHS.

Financing

Reimbursement for services provided to IHS eligible individuals will be provided at 100% federal matching assistance percentage.

For all services provided under the demonstration, the CRIHB would utilize a claiming protocol that would be administered by the CRIHB through a third party administrator arrangement that the CRIHB has with the tribal providers in the network. The CRIHB

network providers would submit certified claims through an encounter-based claiming protocol, which in turn will be rolled up and submitted to the state. The state would reimburse the CRIHB for the claims. Reimbursement would then be remitted to the CRIHB providers.

The CRIHB would be permitted to bill network providers a third party administration fee pursuant to a contract with CRIHB. The CRIHB would be eligible to receive reimbursement for administrative costs through the use of a CPE methodology. Claiming protocols will be developed during the forthcoming consultation process with CMS.

Preliminary Cost Estimates for Proposal

Number of potential eligible beneficiaries:[1]		1300	***x***
IHS Global Encounter Rate for primary care services:[2]		$342.00	***x***
Average number of encounters per individual per year:[3]		3	
	=	$1,333,800	

Budget Neutrality

The total computable costs for the waiver amendment will be accounted for on the total computable "with waiver" side of budget neutrality. The projected cost of $1,333,800 would be added to the existing reimbursement limit in Demonstration Year 10.

Waiver Authority

We believe the existing waivers for freedom of choice, statewideness, and comparability can encompass the proposed amendment. To the extent necessary, we ask that our authority to operate under these waivers extend to amendments contained in this request.

Special Terms and Conditions and Expenditure Authority

The proposed waiver amendment will require expenditure authority. The attached proposed STCs reflect changes to the following sections:

- Program Description and Historical Context
- 29. Implementation of Evaluation Design
- STC 39 (b)(iii) – Safety Net Care Pool Expenditure – SNCP Uncompensated Care

[1] CRIHB Options: Continuance and Proposed Changes in 2015, September 29, 2014
[2] 67 Federal Register No. 79, 19345 April 8, 2014, reimbursement Rate for Calendar year 2014
[3] List source Characteristics of the Medi-Cal Population Likely to Be Impacted by State Plan Amendment (SPA) Number 11-013 to Limit Beneficiaries to no more than Seven Physician Visits per Year, July 2012, *California California Research and Analytical Studies Branch.*

- Attachment F - Supplement 7

Public Notice and Tribal Notice

- As required by STC Paragraph 14, DHCS released tribal notification of the proposal to amend the Section 1115 Waiver, on October 9, 2014.
- The amendment proposal to extend the program for the specified population was also posted to the DHCS Indian Health Program website on October 9, 2014: http://www.dhcs.ca.gov/services/rural/Documents/WaiverAmend1115BTR_10_9_14.pdf.

Questions and comments received regarding the proposed demonstration, along with DHCS responses, are posted on the DHCS Indian Health Program's website at: http://www.dhcs.ca.gov/services/rural/pages/tribal_notifications.aspx.

Thank you for your assistance and consideration. We are happy to assist you and your staff in any way as you review the proposed amendment. If you have any questions, please contact Danielle Stumpf, at (916) 440-7400.

Sincerely,

ORIGINAL SIGNED BY TOBY DOUGLAS

Toby Douglas
Director

Enclosures:

- Proposed STCs (including update to Attachment F Supplement 7)
- Budget Neutrality Worksheet
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Cc:

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was adopted to better coordinate Medicare and Medicaid benefits for dual eligibles, mandatorily enroll dual eligibles into managed care plans and to include long term services and supports (LTSS) as managed care benefits. The primary goals and objectives of the CCI are to improve health outcomes and beneficiary satisfaction for Medi-Cal recipients, while achieving savings from rebalancing service delivery away from institutional care and into the home and community.

The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara and is effective no sooner than April 1, 2014 (date dependent on the signing of the Cal MediConnect 3-way contracts and Medicaid managed care contracts).

The three major components of the CCI are:

- ***Cal MediConnect:*** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries that will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a single health plan.

  The framework for the Cal MediConnect program was approved by the federal Centers for Medicare & Medicaid Services (CMS) and documented in a Financial Alignment Demonstration Memorandum of Understanding (MOU) between CMS and the California Department of Health Care Services (DHCS) signed on March 27, 2013.
- ***Mandatory Enrollment of Dual Eligibles into Medi-Cal Managed Care*:** All dual eligible beneficiaries, subject to certain exceptions, will be mandatorily enrolled in a Medi-Cal managed care organization to receive their Medi-Cal benefits. This includes beneficiaries who opt out or are excluded from enrollment in a Cal MediConnect plan.
- ***Inclusion of Long Term Services and Supports (LTSS):*** Beneficiaries enrolled in a Medi-Cal managed care organization, subject to certain exemptions, will receive their long-term services and supports (LTSS) through the plans.

  Long-term services and supports include the following home- and community-based services: In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) as defined in VIII Operation of Demonstration Programs C. Community-Based Adult Services STCs 91-97 Multipurpose Senior Services Program (MSSP), and nursing facility care services.

On October 30, 2013, California submitted an amendment to add the new adult group to the demonstration's delivery system and to carve in additional behavioral health benefits into managed care.

On November 7, 2013, the state submitted an amendment to extend uncompensated care payments for tribal providers for certain optional services until December 31, 2014.

On November 24, 2014, the state submitted an amendment to extend uncompensated care payments for tribal providers for certain optional benefits from January 1, 2015 through October 31, 2015.

a. Population related Reporting - Within the final Demonstration and evaluation report the State will include:
   i. An assessment using pre-mandatory enrollment as a baseline of the impact on mandatory managed care on the SPD population, including all notable findings;
   ii. An assessment using pre-mandatory enrollment as a baseline of the impact on mandatory managed care on the 2013 managed care expansion, including all notable findings;
   iii. Baseline assessment of populations enrolled who have family incomes at or below 133 percent FPL, and above 133 percent through 200 percent FPL.

28. **Evaluation Design.** Within 120 days of the effective date of these STCs, the state must submit to CMS for approval a draft evaluation design for the demonstration.
   a. At a minimum, the draft design will discuss the outcome measures, which will be used in evaluating the impact of each demonstration related program during the period of approval, particularly among the target populations. The design will also include the specific hypotheses being tested including an evaluation of the effectiveness of using SNCP funding for demonstration related programs. Further, it will discuss the data sources and sampling methodology for assessing these outcomes, including the per capita cost of each demonstration program. Finally, the draft evaluation design will include a detailed analysis plan that describes how the effects of all demonstration programs will be isolated from other initiatives occurring in the state.
   b. State shall include an assessment, using pre-mandatory enrollment as a baseline, of the impact on mandatory managed care on the SPD population, including all significant and notable findings based on all of the data accumulated through the quarterly progress report. The state will submit its plan for CMS review and approval for this aspect of the evaluation.
   c. CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State will submit a final evaluation design within 60 days of receipt of CMS' comments.

29. **Implementation of Evaluation Design.**
   a. The state will implement the evaluation design and submit its progress in each of the quarterly and annual progress reports, including updates on revisions to the evaluation design due to subsequent amendments to the demonstration.
   b. CMS shall provide comments within 60 days after receipt of the report. The state will submit the final evaluation report within 60 days after receipt of CMS comments.
   c. California must conduct an independent evaluation of the uncompensated care payments provided to IHS and 638 facilities as described in STC 39.b.iii and submit interim evaluation findings by ~~June 30~~January 31, ~~2014~~2015.
      i. The evaluation must test the following specific hypotheses related to the uncompensated care payments:
         1. What is the effect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?

Notwithstanding the total computable annual limits specified above, reallocated funds in the amount of $97 million and $26 million, from the HCCI component from DY8 and DY9 of those years, respectively, will be added to the total computable annual limit listed above for DY8 and DY9, respectively. If the available SNCP Uncompensated Care expenditures in DY8 or DY9 are not sufficient to fully claim the reallocated funds, those funds will be made available for SNCP Uncompensated Care expenditures in later demonstration years notwithstanding the total computable annual limits specified above.

The annual limit the State may claim FFP for DSHP is limited to the programs listed below and shall not exceed $400,000,000 FFP per year for a 5 year total of $2,000,000,000 FFP.

The annual limit for the IHS uncompensated care cost shall be $15,461,000 TC per year (DYs 8, 9) for a 2 year total of $30,922,000 TC.

The total annual limit for the extension of the IHS uncompensated care cost claiming for the period January 1, 2014 through December 31, 2014 shall be $3,100,000 total computable. This is comprised of a limit of $1,550,000 total computable in the second half of DY 9 (January 1, 2014 through June 30, 2014) and a limit of $1,550,000 total computable in the first half of DY 10 (July 1, 2014 through December 31, 2014).

The total annual limit for the extension of the IHS uncompensated care cost for January 1, 2015 through October 31, 2015 shall be $1,333,800 total computable.

iii. *Approved Designated State Health Programs (DSHP)* for which FFP can be claimed subject to the limits in this paragraph are:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIALTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Cancer Detection Programs; Every Woman Counts (CDP: EWC)
County Medical Services Program (CMSP) – for the period November 1, 2010 through December 31, 2011 only

Attachment F – Supplement 7

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

The methodology outlined below has been approved for structuring supplemental payments to IHS and 638 facilities from April 5, 2013 through ~~December 31, 2014~~October 31, 2015 as required by 39.b.iii. Using the methodology described below in section (A), the state shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to account for the uncompensated costs of furnishing primary care services between April 5, 2013 and December 31, 2013 to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low Income Health Program (LIHP). Using the methodology described below in section (A) and (B), the state shall also make supplemental payments to account for the uncompensated costs of furnishing services between April 5, 2013 and ~~December 31, 2014~~October 31, 2015 to individuals enrolled in the Medi-Cal program for benefits that were eliminated from the state plan pursuant to state plan amendment 09-001 and are not covered by Medi-Cal.~~.~~

A. Provider Claiming Methodology for services provided April 5, 2013 through December 31, 2013

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The service provided;
    b. Whether the service was provided to an IHS eligible individual;
    c. Whether the service was provided to an uninsured individual;
    d. Whether the service was provided to a Medi-Cal beneficiary; and
    e. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating facilities shall have procedures to determine if individuals are Medi-Cal eligible or uninsured, and if uninsured to determine their income level (which could include a protocol based on self-attestation) and whether they are enrolled in LIHP.
5. Participating IHS and tribal 638 facilities shall maintain existing policies for pursuing third party liability, and shall have procedures to ensure that individuals who have a source of third party liability are not considered uninsured.
6. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by type of qualifying uncompensated service (primary care or formerly Medi-Cal), type of individual (uninsured or Medi-Cal individual) and status of individual as IHS-eligible (Indian or Alaskan Native).

Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third party payments received for Medi-Cal beneficiaries for qualifying

7. uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
8. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1.A) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.
9. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

B. Provider Claiming Methodology for services provided January 1, 2014 through ~~December 31, 2014~~ October 31, 2015.

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The qualifying Medi-Cal service provided to a Medi-Cal beneficiary;
    b. Whether the service was provided to an IHS eligible individual; and
    e. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by status of individual as IHS-eligible (Indian or Alaskan Native).
5. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
6. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1.B) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

State Payment Process

1. The state shall make supplemental payments to each participating facility through CRIHB within 30 days of receipt of each quarterly report, based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published rate, offset by any third party payments received by each IHS/Tribal 638 facility for uncompensated encounters involving Medi-Cal beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other Medi-Cal payments to the facility by the amount of such payments.
2. The state shall terminate supplemental payments if the cap for the SNCP is met.
3. The CRIHB must maintain, and upon request provide DHCS, documentation sufficient to support the claims for supplemental payments.
4. CRIHB will disburse the supplemental payments received from the state to each IHS facility in accordance with its agreement with each facility, but no later than 20 business days after receipt from the state.
8. The State may claim federal matching funding for supplemental payments to IHS and tribal 638 at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated care furnished to IHS eligible individuals.

Exhibit 1.A: Aggregate ~~Enounter~~ Encounter Report for April 5, 2013 through December 31, 2013

Facility Name	IHS Eligible Individuals	
	Uninsured: non-LIHP/non-Medi-Cal	Medi-Cal beneficiaries
Total Number of Encounters		
	X	**x**
IHS Encounter rate		
Total Expenditures		
Less: Any other payments received		
Total Net Expenditures		

Attachment F – Supplement 7

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

Exhibit 1.B: Aggregate ~~Enounter~~ Encounter Report for January 1, 2014 through ~~December 31, 2014~~ October 31, 2015

Facility Name	IHS Eligible Medi-Cal Beneficiaries
Total Number of Encounters	
	X
IHS Encounter rate	
Total Expenditures	
Less: Any other payments received	
Total Net Expenditures	

Certification:

I HEREBY CERTIFY THAT:

1. I have examined this statement, for the period from XXX to XXX and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the IHS/Tribal 638 facilities and CRIHB.

2. The information contained in this report is current, complete, and accurate.

_____ _____

Signature (officer of the governmental entity) Date

_____

Title